



Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
Cancer and Chronic Disease Bureau
Office of Oral Health

Grant Program Application
FY 2018 Oral Disease and Injury Prevention and
School Dental Sealant Grants
Component 1: Oral Disease & Injury Prevention

201 West Preston Street, Room 427
Baltimore, MD 21201
Tel: 410-767-7899; Fax: 410-333-7392
Email: dhmh.ugaoralhealth@maryland.gov
Website: <http://phpa.dhmh.maryland.gov/oralhealth>

Name of Jurisdiction:

Amount of Funds Requested:

Attach a separate word document with response to sections A and B of this application. Attach the provided budget form for section C.

Section A: Program Description & Funding (3-5 pages)

1. Provide a comprehensive description of the proposed program with goals and objectives. See page 5 of the RFA for project objectives.
2. Provide detailed outputs and activities that correspond to the goals and objectives listed above.
3. Describe the staff and organization structure to be used in implementing this program, including description of capacity to successfully implement the proposed activities.
4. Discuss the intended target population and summarize their needs.
5. Describe how this project will impact your community.
6. If you are requesting additional funds -- above what was awarded in fiscal year 2017, describe what additional and/or different activities you will pursue.

Section B: Program Component & Evaluation (1-2 pages)

1. Provide an evaluation plan with an ambitious set of targets and/or milestones to measure progress towards each objective described in section A.
2. Does your program have the following (please select all that apply):
 - ☐ Off-site Oral Cancer Program
 - ☐ Off-site School –Based, Linked, Mobile
 - ☐ Pregnant Women Component
3. Complete the table below indicating program components and anticipated reach.

Program Component	Anticipated Reach
<i>Please Select all that Apply:</i>	<i>Please Enter Anticipated Reach for Selected Program Component(s):</i>
<input type="checkbox"/> On-site Clinical Services	
<input type="checkbox"/> Number of Patients Seen (Children)	
<input type="checkbox"/> Number of Clinical Visits (Children)	
<input type="checkbox"/> Case Management (Children)	
<input type="checkbox"/> Number of Patients Seen (Adults)	
<input type="checkbox"/> Number of Clinical Visits (Adults)	
<input type="checkbox"/> Case Management (Adults)	
<input type="checkbox"/> Off-Site Services	
<input type="checkbox"/> Oral Health Education	
<input type="checkbox"/> Fluoride Varnish	
<input type="checkbox"/> Fluoride Rinse	
<input type="checkbox"/> Toothbrush prophylaxis	

<input type="checkbox"/> Early Head Start	
<input type="checkbox"/> Head Start	
<input type="checkbox"/> Judy Center	
<input type="checkbox"/> WIC	
<input type="checkbox"/> Oral Cancer	
<input type="checkbox"/> Medical & Dental Provider Education	
<input type="checkbox"/> Screenings	
<input type="checkbox"/> Referrals	
<input type="checkbox"/> Water Fluoridation	
<input type="checkbox"/> Well Testing & Equipment	

Section C: Program Funding

1. Identify other sources of funding in addition to the Office of Oral Health that will be used for the proposed activities in the table below.

<i>Please Select all that Apply</i>	Funding Source	Amount of Funding Source
<input type="checkbox"/>	Medicaid Collections*	Amount:
<input type="checkbox"/>	Private Insurance Collections*	Amount:
<input type="checkbox"/>	Other Grants:	Amount:
<input type="checkbox"/>	Other:	Amount:
<input type="checkbox"/>	Other:	Amount:

* Based on most recent collections

2. Submit a twelve (12) month budget narrative using the budget form supplied with your application, with supporting justification and documentation as per the usual instructions for the DHMH Unified Grant Award along with this completed application to dhmh.ugaoralhealth@maryland.gov.

Section D: Contact Information

Contact Position	Name	Phone	Email
Application Preparer:			
Quarterly Report Contact:			
Fiscal Report Contact:			